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APPLICATION NO.	FILING DATE	FIRST NAMED INVENTOR	ATTORNEY DOCKET NO.	CONFIRMATION NO.
09/922,297	08/03/2001	Jane I. Potter	4371-000002	9688

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Bryan K. Wheelock
Harness, Dickey & Pierce, P.L.C.
Suite 400
7700 Bonhomme
St. Louis, MO 63105

EXAMINER	
FRENEL, VANEL	

ART UNIT	PAPER NUMBER
3626	

DATE MAILED: 03/03/2006

Please find below and/or attached an Office communication concerning this application or proceeding.

Office Action Summary	Application No.	Applicant(s)	
	09/922,297	POTTER ET AL.	
	Examiner	Art Unit	
	Vanel Frenel	3626	

-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) OR THIRTY (30) DAYS, WHICHEVER IS LONGER, FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133). Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

Status

1)☒ Responsive to communication(s) filed on *03 August 2001*.

2a)☐ This action is **FINAL**. 2b)☒ This action is non-final.

3)☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

Disposition of Claims

4)☒ Claim(s) *1-45* is/are pending in the application.

4a) Of the above claim(s) _____ is/are withdrawn from consideration.

5)☐ Claim(s) _____ is/are allowed.

6)☒ Claim(s) *1-45* is/are rejected.

7)☐ Claim(s) _____ is/are objected to.

8)☐ Claim(s) _____ are subject to restriction and/or election requirement.

Application Papers

9)☐ The specification is objected to by the Examiner.

10)☐ The drawing(s) filed on _____ is/are: a)☐ accepted or b)☐ objected to by the Examiner.

Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).

Replacement drawing sheet(s) including the correction is required if the drawing(s) is objected to. See 37 CFR 1.121(d).

11)☐ The oath or declaration is objected to by the Examiner. Note the attached Office Action or form PTO-152.

Priority under 35 U.S.C. § 119

12)☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).

a)☐ All b)☐ Some * c)☐ None of:

1.☐ Certified copies of the priority documents have been received.

2.☐ Certified copies of the priority documents have been received in Application No. _____.

3.☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).

* See the attached detailed Office action for a list of the certified copies not received.

Attachment(s)

1) ☒ Notice of References Cited (PTO-892)
2) ☐ Notice of Draftsperson's Patent Drawing Review (PTO-948)
3) ☒ Information Disclosure Statement(s) (PTO-1449 or PTO/SB/08) Paper No(s)/Mail Date *7292002*.
4) ☐ Interview Summary (PTO-413) Paper No(s)/Mail Date. _____.
5) ☐ Notice of Informal Patent Application (PTO-152)
6) ☐ Other: _____.

DETAILED ACTION

Notice to Applicant

1. This communication is in response to the application filed on 08/03/01. Claims 1-45 are pending.

Claim Rejections - 35 USC § 103

2. The following is a quotation of 35 U.S.C. 103(a) which forms the basis for all obviousness rejections set forth in this Office action:

> (a) A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negatived by the manner in which the invention was made.

3. Claims 1-45 are rejected under 35 U.S.C. 103(a) as being unpatentable over Torma et al (5,365,425) in view of Lockwood et al (5,845,254).

3. (A) As per claim 1, Torma discloses a method of compensating a health service provider providing health services in service episodes to health plan members (See Torma, Col. 5, lines 20-68), the method comprising sharing a portion of the cost savings resulting from the provider's reduction of actual average cost per service episode compared to a predetermined budgeted average cost per service episode (See Torma, Col.9, lines 6-48).

Torma does not explicitly disclose that the method having a portion depending in part upon the provider's average cost per service episode compared to an average cost per service episode of providers to the members, and in part upon the provider's performance on at least one of a quality measure and a member satisfaction measure.

However, this feature is known in the art, as evidenced by Lockwood. In particular, Lockwood suggests that the method having a portion depending in part upon the provider's average cost per service episode compared to an average cost per service episode of providers to the members, and in part upon the provider's performance on at least one of a quality measure and a member satisfaction measure (See Lockwood, Col.12, lines 67 to Col.14, line 15; Col.14, lines 1-17).

It would have been obvious to one of ordinary skill in the art at the time of the invention to have included the feature of Lockwood within the system of Torma with the motivation of providing a cost efficiency performance level which is determined for each individual health-care provider within the group of healthcare providers from the plurality of severity-adjusted sickness episode data records, and a qualitative performance level which determined for the group of healthcare providers as a whole (See Lockwood, Col.5, lines 41-47).

(B) As per claim 2, Lockwood discloses the method wherein the provider's actual average cost per service episode and the budgeted average cost per service episode are indexed to the same level of episode severity before comparison (See Lockwood, Col.10, lines 55-67 to Col.11, line 30).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claim 1 above, and incorporated herein.

(C) As per claim 3, Lockwood discloses the method wherein the provider's actual average cost per service episode and the average cost per service episode of care of providers to the members of the health plan are indexed to the same level of episode severity before comparison (See Lockwood, Col.11, lines 1-31).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claim 1 above, and incorporated herein.

(D) As per claim 4, Torma discloses the method wherein the portion of the cost savings shared with the provider depends upon whether the provider's average cost per service episode is above or below the median average cost per service episode of care of providers to the members of the health plan (See Torma, Col.7, lines 43-68 to Col.8, line 59).

(E) As per claim 5, Torma discloses the method wherein the portion of the cost savings shared with the provider depends in part upon the provider's performance on a quality measure (See Torma, Col.7, lines 43-68 to Col.8, line 59).

(F) As per claim 6, Lockwood discloses the method wherein the portion of the cost savings shared with the provider depends in part upon the provider's performance on a member satisfaction measure (See Lockwood, Col.12, lines 67 to Col.14, line 15; Col.14, lines 1-17).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claim 1 above, and incorporated herein.

(G) As per claim 7, Lockwood discloses the method wherein the portion of the cost savings shared with the provider depends in part upon the provider's performance on a measure of quality measure and member satisfaction (See Lockwood, Col.12, lines 67 to Col.14, line 15; Col.14, lines 1-17).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claim 1 above, and incorporated herein.

(H) As per claim 8, Torma discloses the method wherein the service provider is a group of individuals (See Torma, Col.5, lines 20-68).

(I) As per claim 9, Lockwood discloses the method wherein the service provider is a group of individuals in a particular medical specialty, and wherein the comparison between the provider's average cost per service episode and an average cost per service episode of care of providers providing service to the members of the health plan is made with providers in the same medical specialty (See Lockwood, Col.54-67 to Col.8, lines 17).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claim 1 above, and incorporated herein.

(J) As per claim 10, Torma discloses a method of compensating a group of physicians providing health services in service episodes to health plan members (See Torma, Col.5, lines 20-68), the method comprising sharing a portion of the cost savings resulting from the reduction of the group's actual average cost per service episode compared to a predetermined budgeted average cost per service episode (See Torma, Col.9, lines 6-48).

Torma does not explicitly disclose that the portion depending in part upon the group's average cost per service episode compared to an average cost per service episode of groups providing service to the members, and in part upon the group's performance on at least one of a quality measure and a member satisfaction measure.

However, this feature is known in the art, as evidenced by Lockwood. In particular, Lockwood suggests that the portion depending in part upon the group's average cost per service episode compared to an average cost per service episode of groups providing service to the members, and in part upon the group's performance on at least one of a quality measure and a member satisfaction measure (See Lockwood, Col.12, lines 67 to Col.14, line 15; Col.14, lines 1-17).

It would have been obvious to one of ordinary skill in the art at the time of the invention to have included the feature of Lockwood within the system of Torma with the motivation of providing a cost efficiency performance level which is determined for each individual health-care provider within the group of healthcare providers from the plurality of severity-adjusted sickness episode data records, and a qualitative performance level

which determined for the group of healthcare providers as a whole (See Lockwood, Col.5, lines 41-47).

(K) As per claim 18, Torma discloses a method of compensating physicians for managing the cost and quality of healthcare services provided to members of a health plan served by a plurality of physician groups (See Torma, Col.5, lines 20-68), the method comprising:

developing a budgeted cost per episode of patient for a program period for at least one physician group based at least in part on the historic actual performance of the group (See Torma, Col.12, lines 42-68);

compiling data on actual cost per episode of patient care during the program period (See Torma, Col.8, lines 6-67);

comparing the group's actual cost per episode of patient care during the program period with the group's budgeted cost per episode of patient care for the program period, adjusted for changes in the severity of illness of the patients treated (See Torma, Col.8, lines 6-68).

Torma does not explicitly disclose that the method having sharing a portion of the savings resulting from a reduction in actual cost per episode of patient care with the group, the portion depending upon the group's performance on a quality and/or patient satisfaction indicator.

However, this feature is known in the art, as evidenced by Lockwood. In particular, Lockwood suggests that the method having sharing a portion of the savings

resulting from a reduction in actual cost per episode of patient care with the group, the portion depending upon the group's performance on a quality and/or patient satisfaction indicator (See Lockwood, Col.12, lines 54- 67 to Col.14, line 15; Col.14, lines 1-17).

It would have been obvious to one of ordinary skill in the art at the time of the invention to have included the feature of Lockwood within the system of Torma with the motivation of providing a cost efficiency performance level which is determined for each individual health-care provider within the group of healthcare providers from the plurality of severity-adjusted sickness episode data records, and a qualitative performance level which determined for the group of healthcare providers as a whole (See Lockwood, Col.5, lines 41-47).

(L) As per claim 19, Lockwood discloses the method wherein the sharing of a portion of the savings is also dependent on the group's performance relative to other physicians (See Lockwood, Col.15, lines 30-67).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(M) As per claim 20, Lockwood discloses the method wherein the sharing of a portion of the savings of a group is dependant on a comparison of a measure of the group's cost per episode of patient care with a measure of other physicians' cost per episode of patient care (See Lockwood, Col.15, lines 1-56).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(N) As per claim 21, Lockwood discloses the method wherein the measure of the group's cost per episode of patient care and the measure of other physicians' cost per episode of patient care in indexed to the same level of episode severity before comparison (See Lockwood, Col.5, lines 28-47).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(O) As per claim 22, Lockwood discloses the method wherein the portion of savings shared with the group depends upon the group's performance on a quality indicator relative to other physicians' performance on the quality indicator (See Lockwood, Col.4, lines 14-40).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(P) As per claim 23, Lockwood discloses the method wherein the quality indicator includes a measurement of the number of patients with a particular diagnosis receiving a particular treatment (See Lockwood, Col.4, lines 14-56).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(Q) As per claim 24, Lockwood discloses the method wherein the quality indicator includes a measurement of the number of patients with a particular diagnosis not receiving a particular treatment (See Lockwood, Col.7, lines 42-67).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(R) As per claim 25, Lockwood discloses the method wherein the quality indicator includes measurement based on survey responses of plan members treated by the group (See Lockwood, Col.12, lines 35-67).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(S) As per claim 26, Lockwood discloses the method wherein a group's budgeted cost per episode of patient care is determined based at least in part on the historic performance of the individual physicians in the group (See Lockwood, Col.12, lines 4-34).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(T) As per claim 27, Lockwood discloses the method wherein the weight given to the historic performance of an individual physician in the group depends upon that physician's total number of episodes of care (See Lockwood, Col.11, lines 1-31).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(U) As per claim 28, Lockwood discloses the method wherein the weight given to the historic performance of an individual physician in the group depends upon the physician's number of episodes of care and the physician's medical specialty (See Lockwood,Col.6, lines 35-67; Col.9, lines 33-67).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(V) As per claim 29, Lockwood discloses the method wherein the budgeted cost per episode of patient care and the actual cost per episode of patient care exclude outpatient prescription pharmaceuticals (The Examiner interprets medical facilities to be a form of outpatient prescription pharmaceuticals See Torma, Col.7, lines 43-68).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(W) As per claim 30, Lockwood discloses the method wherein the comparison between group's actual cost per episode of patient care during the program period with

the group's budgeted cost per episode of patient care for the program period, is adjusted to take into account inflation between the time of the budget and the program period (See Lockwood, Col.12, lines 35-67).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(X) As per claim 31, Lockwood discloses the method wherein the adjustment to take into account inflation is implemented by increasing the group's budgeted cost per episode of patient care (See Lockwood, Col.5, lines 1-22).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(Y) As per claim 32, Lockwood discloses the method wherein the adjustment to take into account inflation is implemented by decreasing the group's actual cost per episode of patient care (See Lockwood, Col.4, lines 29-56).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10 and 18 above, and incorporated herein.

(Z) As per claim 33, Torma discloses the method wherein the adjustment for changes in the severity of illness of the patients treated comprises indexing the relative costs of the episodes of care used in determining budgeted cost per episode of patient

care, and the relative costs of the episodes of care used in determining the actual cost per episode of patient care (See Torma, Col.8, lines 6-68).

(AA) As per claim 34,Torma discloses a method managing the cost of heath services provided to members of a health plan served by a plurality of physician groups, by compensating physician groups for managing the cost and quality of health care services (See Torma, Col.5, lines 20-68), the method comprising:

Torma does not explicitly disclose that the method having sharing with a group a portion of the cost savings resulting from that group's reduction in the cost episode of patient care during a period from a predetermined budgeted cost per episode of patient care for that period, the portion being determined at least in part by the group's performance on a quality and/or patient satisfaction indicator.

However, this feature is known in the art, as evidenced by Lockwood. In particular, Lockwood suggests that the method having sharing with a group a portion of the cost savings resulting from that group's reduction in the cost episode of patient care during a period from a predetermined budgeted cost per episode of patient care for that period, the portion being determined at least in part by the group's performance on a quality and/or patient satisfaction indicator (See Lockwood, Col.12, lines 54- 67 to Col.14, line 15; Col.14, lines 1-17).

It would have been obvious to one of ordinary skill in the art at the time of the invention to have included the feature of Lockwood within the system of Torma with the motivation of providing a cost efficiency performance level which is determined for each

individual health-care provider within the group of healthcare providers from the plurality of severity-adjusted sickness episode data records, and a qualitative performance level which determined for the group of healthcare providers as a whole (See Lockwood, Col.5, lines 41-47).

(BB) As per claim 37, Lockwood discloses the method wherein the weight give to a group's historical performance depends upon the number of years of data for the group (See Lockwood, Col.10, lines 3-54).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10, 18 and 38 above, and incorporated herein.

(CC) As per claim 38, Lockwood discloses the method wherein the weight given to a group's historical performance depends upon the number of years of data for the group and the group's specialty (See Lockwood, Col.10, lines 3-54).

The motivation for combining the respective teachings of Torma and Lockwood are as discussed in the rejection of claims 1, 10, 18 and 38 above, and incorporated herein.

(DD) Claims 11-17, 35-36 and 39-45 recite the underlying process steps of the elements of claims 2-7, 9, 19-26 and 28 respectively. As the various elements of claims 2-7, 9, 19-26 and 28 have been shown to be either disclosed by or obvious in view of

the collective teachings of Torma and Lockwood, it is readily apparent that the method by the applied prior art performs the recited underlying functions. As such, the limitations recited in claims 11-17, 35-36 and 39-45 are rejected for the same reasons given above for method claims 2-7, 9, 19-26 and 28, and incorporated herein.

Conclusion

4. The prior art made of record and not relied upon is considered pertinent to applicant's disclosure. The cited but not the applied art teaches method and system for generating statistically-based medical provider utilization profiles (6,223,164) and method and system for management of patient accounts (2002/0026328).

Any inquiry concerning this communication or earlier communications from the examiner should be directed to Vanel Frenel whose telephone number is 571-272-6769. The examiner can normally be reached on Monday-Thursday from 6:30am-5:00pm.

If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Joseph Thomas can be reached on 571-272-6776. The fax phone number for the organization where this application or proceeding is assigned is 571-273-8300.

Information regarding the status of an application may be obtained from the Patent Application Information Retrieval (PAIR) system. Status information for published applications may be obtained from either Private PAIR or Public PAIR. Status information for unpublished applications is available through Private PAIR only. For more information about the PAIR system, see http://pair-direct.uspto.gov. Should you have questions on access to the Private PAIR system, contact the Electronic Business Center (EBC) at 866-217-9197 (toll-free).

V.F
V.F

November 17, 2005

JOSEPH THOMAS
SUPERVISORY PATENT EXAMINER